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Case Report

ENDOMETRIAL POLYP: SHORT REVIEW OF LITERATURE & TREATMENT OPTIONS. IS EVERY POLYP MALIGNANT?

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INTRODUCTION

An endometrial polyp or uterine polyp is a mass in the inner lining of uterus. They may have a large flat base (sessile) or be attached to the endometrium by an elongated pedicle (pedunculated). Pedunculated polyps are more common than sessile ones. They are oval or round in shape and range in size from a few millimetres to several centimetres. Pedunculated polyp can protrude through the cervix into the vagina. Small blood vessel may be present particularly in large polyp. The majority of polyps are benign, however, the small number of polyps that are malignant might be influencing how the majority of diagnosed polyps are being treated. Malignancy arising in polyps is uncommon and specific risks for malignancy include increasing age and postmenopausal bleeding (Hartman *et al.,* 2011).

Keywords: *Endometrial Polyp, Pedunculated, Sessile, Uterine Polyp, Benign/Malignant Endometrial Polyp*

CASES

A female patient aged 43 years, a multigravida, presented with history of pain lower abdomen for 1 year, scanty menses, and white discharge per vagina. Menstrual history was 2-3/28-30 days associated with pain.

Obstetric history was P3L3 home delivery, tubal ligation was done. Per abdomen examination was normal. Systemic examination revealed normal respiratory system, CVS and CNS. X-Ray chest and ECG were normal.

The speculum examination of the cervix revealed normal cervix with foul smelling whitish discharge. Uterus was anteverted, bulky and bilateral fornices were free.

The rectal examination did not reveal any induration or nodularity of parametrium and rectal mucosa was smooth and freely mobile.

Haematological examination revealed blood group “O” positive; HIV, VDRL and Hbs Ag were non – reactive.

Haemoglobin 12.3 gm%, ESR 15 mm, TLC 6400, N-57% L 33% M 6% E 4%, TRBC 3.25million/cubic mm, platelet 250 000/cubic mm, Blood urea 10.7mg/dl, serum creatinine 0.9 mg/dl .

Urine examination was normal.

Ultrasonography (USG) revealed anteverted uterus measuring 9.6 cm (L) x 6.4 cm (T) x 5.8 cm (AP). The endometrial cavity was distended with fluid facilitating visualisation of an endometrial polyp of 1.9 cm x 1.6 cm in upper portion of endometrial cavity.

The stalk of the endometrial polyp was not identified (Figure 1). Right ovary measured 2.5 cm & left ovary 2.7 cm. Both ovaries were normal. Pouch of Douglas was clear. Adnexa had normal echogenecity. Abdominal USG revealed normal USG findings.

Hysterectomy was done.

Gross specimen revealed a ligamentous polyp in the endometrial cavity measuring 2.5 cm in length. Histopatholog y examination (microscopic examination) showed features of a benign endometrial polyp, endometrium was in proliferative phase, myometrium was normal.

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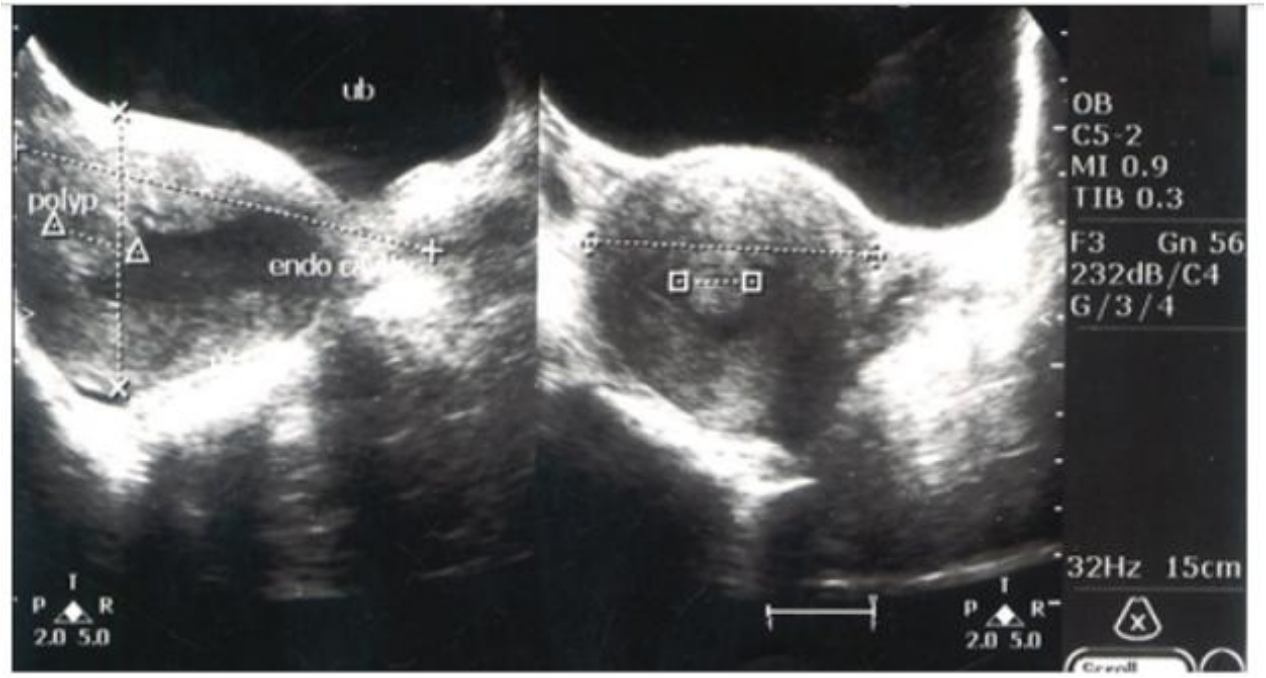

Figure 1: Endometrial polyp attached to anterior surface of endometrium with fluid distension of endometrial cavity

DISCUSSION

Endometrial polyps are a common gynaecologic disease that may be symptomatic, with abnormal vaginal bleeding being the most common presentation. Endometrial polyps usually occur in women in their 40s and 50s. Endometrial polyps are found in 10% to 40% of women suffering from premenopausal bleeding (Reslova *et al.,* 1999) and symptoms do not correlate with polyp number, diameter or location (Peterson *et al.,* 1956). It is estimated that they are present in 25% of women with abnormal vaginal bleeding. The incidence of endometrial polyp is 32 in 1000 infertile woman (Hartman *et al.,* 2011).

No definite cause of endometrial polyps is known, but they appear to be affected by hormone levels and grow in response to circulating oestrogen. They often cause no symptoms and often found when the women are being investigated for other indications. Symptoms include irregular menstrual bleeding, bleeding between menstrual periods, menorrhagia, and vaginal bleeding after menopause. If the polyp protrudes through cervix into the vagina, pain (dysmenorrhoea) may result (Peterson *et al.,* 1956).

In one class II study, 27% of the endometrial polyps regressed spontaneously during a 1-year follow-up.

Polyps are diagnosed by 2-D ultrasound, Colour Doppler sonography (CDS), transvaginal sonography, colour Doppler trans-vaginal sonography or hysterescopy. Non-contrast 3-D TVUS shows limited improvement to diagnosis compared with 2-D TVUS. SIS (saline infused sonography) allows greater diagnostic accuracy.

*Guidelines for recognising the presence of endometrial polyps (*Goldstein *et al., 2002)*

1. Increasing age is the most common risk factor for the presentation of an endometrial polyp
2. For women with symptoms with a polyp, abnormal uterine bleeding is the most common presenting symptom
3. Infertile women are more likely to be diagnosed with an endometrial polyp
4. Polyps may naturally regress in up to 25% of patients, with small polyps more likely to resolve spontaneously.
5. Medications such as tamoxifen may predispose to the formation of endometrial polyps

*Guidelines for the diagnosis of Endometrial Polyps (*Goldstein *et al., 2002)*

1. TVUS is the investigation of choice

2. The addition of colour or power Doppler increases the capacity of TVUS to diagnose endometrial polyps.
3. Adding intrauterine contrast to sonography (with or without 3-D imaging) improves the diagnostic capacity for endometrial polyps.
4. Blind dilatation and curettage or biopsy should not be used for diagnosis of endometrial polyps.

Guidelines for management of Endometrial polyp (Goldstein *et al., 2002)*

1. Conservative management is reasonable particularly for small polyps and if asymptomatic.
2. Medical management of polyps cannot be recommended at this time.
3. Hysteroscopic polypectomy remains the gold standard for treatment.
4. There does not appear to be differences in clinical outcomes with different hysteroscopic polypectomy techniques.
5. Hysteroscopic removal is to be preferred to hysterectomy because of its less-invasive nature, low cost and reduced risk to the patient.

Given that the most polyps are not malignant, there is an option for expectant management with no intervention.

Polyps may regress spontaneously in approximately 25% of cases. Smaller polyps are more likely to regress compared with polyps >10 mm in length. Polyp size also appears to be a risk indicator of malignancy within endometrial polyp (Anastasiadis *et al.,* 2000; Ferrazzi *et al.,* 2009; Shushan *et al.,* 2004). Asymptomatic post-menopausal polyps are unlikely to be malignant. However, malignancy should be excluded histologically. About 0.5% of endometrial polyps contain adenocarcinoma cells (Hartman *et al.,* 2011).

Hysyeroscopic polypectomy is effective and safe as both a diagnostic and therapeutic intervention. Hysteroscopy and electro-surgical removal of polyps is both commonly available and of relatively low cost (Emanuel *et al.,* 2005).

Intrauterine adhesion risk is low after polypectomy because the myometrium is not incised.

Hysterectomy guarantees no polyp recurrence and no potential for malignancy having greater costs and potential for morbidity. It should be used judiciously and only after discussion with the patient about its implication. Symptomatic polyps should be removed in the premenopausal or postmenopausal woman because evidence reports improvement in symptoms, with abnormal uterine bleeding after hysteroscopic polypectomy resolving in 75% to 100% of cases. A hysterectomy would usually not be considered if cancer has been ruled out. Although recurrence of endometrial polyps is frequent; untreated small polyps may regress on their own. A ***"watch and wait"*** course of action for patients diagnosed with endometrial polyps may be the best course of action (Hartman *et al.,* 2011).

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